STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/07/11 Facility Number: 000483 Provider Number: 15E657 AIM Number: 100273470 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Silver Memories Health Care was found not in compliance with Requirements for Participation in Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 29 and had a census of 18 at the time of this visit.	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/09/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0018 SS=E	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 27 corridor doors would latch and resist the passage of smoke with no impediment to closing the door. This deficient practice affects 8 residents who reside in West Hall in rooms 1, 2, 3, 4, and 5. Findings include: Based on observation on 09/07/11 at 12:35 p.m. with the administrator, the door to resident room 4 failed to latch into	K0018	K0018The maintenance man reviewed all doors in the facility to ensure that they would latch and resist the passage of smoke. The maintenance man repaired room 4's door to allow it to latch properly. All staff is responsible to complete a maintenance report on all doors that will not latch. The maintenance man will be responsible to repair any door the will not latch in a timely manner. The maintenance man will be responsible to review all facility doors latch properly, no less than quarterly.	09/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the door frame leaving a one inch gap along the latching side of the door. This was verified by the administrator at the time of observation 3.1-19(b)			
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and interview, the facility failed to ensure 1 of 6 exit discharge paths was provided with emergency powered illumination. LSC 7.9.1.1 says the exit discharge shall include only designated stairs, aisles walkways leading to a public way. LSC 7.9.2.1 requires emergency lighting shall be provided for not less than 1 1/2 hours arranged to provide not less than an average of 1 foot candle, and not less than 0.1 foot candles, measured along the path of egress at floor level. Further, LSC 7.9.2.4 allows for battery operated emergency lights to use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged conditions. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electrical Code. This deficient practice could affect any residents who would use the south exit door by the laundry room.	K0046	K 0046 The facility ordered 7 weatherized emergency powered lights to replace the exterior emergency powered illumination lights currently in place. The maintenance department will be required to test interior and exterior emergency powered illumination lighting, no less than monthly. Koorsen's Fire Protection and Security are scheduled to conduct a 90 minute test on all emergency powered illumination, annually. The administrator will review all testing, no less than quarterly.	10/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observation with the administrator on 09/07/11 at 12:50 p.m., the south exit door by the laundry room was provided with a double light, battery backup light fixture outside the exit door. The test button was depressed two times and the light failed to illuminate. This was verified by the administrator at the time of observation and testing. 3.1-19(b)			
K0053 SS=F	In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) Based on record review and interview, the facility failed to ensure 10 of 10 battery operated smoke detectors in resident rooms were maintained and a battery replacement program developed to ensure proper operation. This deficient practice could affect all residents in the facility. Findings include:	K0053	K 0053 The facility purchased new smoke detectors and new batteries for 9 of 11 resident bedrooms. 2 of 11 bedrooms have wired smoke detectors in place which are monitored by Koorsen's Fire and Security. The battery operated smoke detectors will be tested following each fire drill. Maintenance will be responsible to replace the batteries twice a year. The administrator will	09/16/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on a review of Fire Alarm System Inspection Reports on 09/07/11 at 12:55 p.m. with the administrator, the most recent report dated 05/04/11 did not list testing or battery replacement for the ten resident room battery operated smoke detectors. Based on an interview with the administrator on 09/07/11 at 1:00 p.m., the facility has not developed a testing and maintenance program for the ten battery operated smoke detectors in resident rooms. 3.1-19(b)		be responsible to review documentation of battery testing on smoke detectors, no less than quarterly.	
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 27 rooms was sprinklered. This deficient practice	K0056	The maintenance man removed a portion of the inside dividing wall to allow the sprinkler on the other side to sprinkler both areas. The	10/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	affects 7 residents who reside on the East Hall in resident rooms 6, 7, and 8 near the linen storage room. Findings include: Based on observation on 09/07/11 at 12:20 p.m. with the administrator, the East Hall linen storage room was not provided with sprinkler coverage. This was verified by the administrator at the time of observation. 3.1-19(b)		sprinkler will be monitored and inspected with all other sprinkler heads.	
K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observations and interview, the facility failed to ensure 3 of 3 corridors were provided with sprinkler heads free of paint. LSC 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2-2.1.1 requires sprinklers to be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (upright, pendent, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K0062	K 0062 All sprinkler heads repaired as needed. The maintenance man is responsible to ensure no paint is on the sprinkler heads and cover sprinkler heads during painting projects. The administrator will visually monitor sprinklers to be free of paint, no less than quarterly.	09/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficient practice could affect all residents in the facility. Findings include: Based on observations on 09/07/11 during a tour of the facility from 11:40 a.m. to 1:25 p.m. with the administrator, the following areas had sprinklers covered in white paint; the open nurses' station sprinkler above the desk, the nurses' station corridor sprinkler across from the main dining room, the corridor sprinkler by the storage room, the corridor sprinkler by resident room 3, the corridor sprinkler by the south exit door, the corridor sprinkler by the soiled linen room, and the corridor sprinkler by resident room 7. The painted sprinklers were verified by the administer at the time of observations. 3.1-19(b)			
K0064 SS=F	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 4 of 4 portable fire extinguishers were inspected at least monthly and the inspections were documented for 2 of 2 months since the annual inspection, including the date and initials of the person performing the inspection. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.4.2 requires at least monthly, the date of inspection and the initials of the person performing the inspection shall be recorded. In addition NFPA 10, 4-2.1 defines inspection as a quick check an	K0064	The maintenance department inspected all fire extinguishers and noted initials in correct month. The maintenance department is responsible to inspect all facility fire extinguishers, monthly. Koorsen's fire and Security is responsible to maintain and check all fire extinguishers, annually.	10/03/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	extinguisher is available and will operate. This deficient practice could affect all clients, visitors and staff. Findings include: Based on observations during a tour of the facility with the administrator on 09/07/11 from 11:40 a.m. to 1:25 p.m., the service and inspection tags for the four portable fire extinguishers located in the kitchen, the East Hall, the West Hall, and the South Hall each bore a service inspection tag indicating the most recent annual inspection was in June 2011, but no monthly checks were documented on the inspection tags for July and August 2011. Based on an interview with the administrator at the time of observations, there is no written documentation of monthly fire extinguisher inspections for the four portable fire extinguishers. 3.1-19(b)			
K0154 SS=F	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the facility failed to include notification of the insurance carrier, alarm company, and authority having jurisdiction in the written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period to protect 18 of 18 residents in accordance with LSC, Section 9.7.6.1. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of a sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice affects all residents in the facility. Findings include: Based on a review of the Fire Watch Policy on 09/07/11 at 1:00 p.m. with the administrator, the Fire Watch Policy lacked notification of the insurance carrier, alarm company, the Indiana State Department of Health and the local fire department. This was verified by the administrator at the time of record review.	K0154	The administrator has reviewed and will revise the facility Fire Watch Policy to include the insurance carrier, Alarm Company, the ISDH and local fire department contact information. On October 21, all staff will be in-serviced on the new implementations noted in the fire Watch Policy, and then with every Disaster Preparedness In-Service.	10/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			
K0155 SS=F	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy for the protection of 18 of 18 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8. LSC, 19.7.1.1 requires every health care occupancy to have in effect and available to all supervisory personnel a plan for the protection of all persons. All employees shall periodically be instructed and kept informed with respect to their duties under the plan. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 requires all fire safety plans to provide for the use of alarms, the transmission of the alarm to the fire department and response to alarms. 19.7.2.3 requires health care personnel to be instructed in the use of a code phrase to assure transmission of the alarm during a malfunction of the building fire alarm system. This deficient practice affects all residents in the facility. Findings include: Based on a review of the Fire Watch Policy on 09/07/11 at 1:00 p.m. with the administrator, the Fire Watch Policy lacked notification of the Indiana State Department of Health and the local fire department. This was verified by the	K0155	The administrator has reviewed and will revise the facility Fire Watch Policy to include the insurance carrier, Alarm Company, the ISDH and local fire department contact information. On October 21, all staff will be in-serviced on the new implementations noted in the fire Watch Policy, and then with every Disaster Preparedness In-Service.	10/21/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E657	A. BUILDING 01 B. WING	09/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MEMORIES HEALTH CARE	6996 S US 421 VERSAILLES, IN47042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administrator at the time of record review. 3.1-19(b)			